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The Chirogram

THE CHIROPRACTIC PHYSICIAN MARCH 1975, VOL 42, NO. 3

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DATES

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Sat-Sun.	August	16-17
Sat-Sun.	September	20-21
*Wed-Thu.	October	15-16
	Elks Club - Glendale	
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EDITORIAL COMMENT

GRUMBLINGS

Life is full of tribulations,
Little things that get to you;
Little mental subluxations —
Here, for instance, are a few:

The traffic officer who "tails" you for miles.

The one who chews gum in your ear while conversing.

People who meet, kiss, greet and talk at the airport, blocking those who are trying to deplane.

The waitress who, uninvited, joins the table conversation.

Left turn drivers, who barely clear the crosswalk, and block you for an extra light.

Those selling cemetary lots on the telephone.

Those selling magazines on the telephone.

Those selling insurance on the telephone.

Those selling ANYTHING on the telephone.

The listener who says "huh?" when it's obvious that he heard you.

Those who end every sentence with "Right?", "See?", or "you know?"

The boor who steals the punch line from your story.

Hogs who straddle the line in a crowded parking lot - taking two spaces.

Tiny cars that slip up on your blind spot, then "tweet" at you.

Then, there are the patients who:

Eat garlic before a twenty minute session under your heat lamp.

Call in the middle of the night with an "emergency" that happened three weeks ago.

Socialize with your CA while others are waiting for service.

Insist upon talking personally to you, when you are with another patient.

Diagnose their own condition, and try to prescribe their own treatment.

Show up an hour late for an appointment, and cannot understand why they have to wait.

And most annoying is the editor who annoys readers writing about annoying people. The people — bless them — are innocent, but the editor --- ah, he wrote with aforethought --- but not with malice.

JDK

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OF THE LOS ANGELES COLLEGE OF CHIROPRACTIC

CIRCULATION — 11,000

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Dedicated to the dissemination of current and research information relative to the field of Chiropractic Therapeutics

FEATURE ARTICLES

REGULAR FEATURES

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A COMPREHENSIVE DIAGNOSTIC EVALUATION IN JUST THIRTY MINUTES

by Richard H. Tyler, D. C.

The patient got dressed. "Doctor," she said, as I was leaving the room, "I've never had such a complete physical in my life." I nodded with a smile and stepped outside to preen a bit. This same thing happened on several other occasions with people who had had extensive medical histories. Histories that included major surgical procedures that would cause someone to presuppose that a rather thorough physical examination had been given before any surgical intervention could take place.

It wasn't long before the personal pride in my thoroughness began to change from pride to wonder. I found it difficult to understand how some diagnosis had been made on such pedestrian diagnostic application. It wasn't that I was so thorough -- it was that so many others weren't. In most cases I found that the physicians that the patient had been to before me were usually in a rush so their examination consisted of saying "Ahhh," breathing deeply and turning the head and coughing. If I had been taught nothing else in school -- diagnosis, it was said, was the prime ingredient in applying the proper therapeutic approach. That made sense. "The proper diagnosis," said one instructor, "not only tells you what you should do but what is just as important -- what you shouldn't do".

While in the clinic all the new externs had to observe and assist in a minimum of five major physical examinations before they were allowed to do one on their own. Like so many others I approached the first physical I was to do with clammy hands and tachycardia. I was terrified that the patient would know or find out how little I thought I knew. With this in mind I was determined to formulate an examination that would be thorough and well organized. Too often I had observed student doctors rambling about for several hours of patient poking until both doctor and patient were in a state of nervous exhaustion. If everything was planned carefully and drilled often enough -- what would have taken at least two hours could be cut down to no more than 30 minutes.

With this concept determined, I set about trying to crystalize the most important diagnostic tools into a pattern consistent with patient comfort and cogent analysis. I developed a small book that I rehearsed like an actor would a script. With refinements through the years the program I developed while a student still serves me well and hence, I believe, to the benefit of my patients.

The first step, of course, is taking a case history. Since there are so many variables I don't include the history as part of the actual examination. Some patients are reticent to communicate with the

doctor and these walls must be at least partially dissolved before concrete progress can be made in the history taking. There are facts elicited in a history which invariably indicate things to look for during the actual examination.

I suppose I could say that my examination begins the minute I meet the patient. The color of the skin, the facies, the way the patient sits, stands and walks are all important. By the time he has reached the examination room I have begun to formulate a physical impression that can either be negated or reinforced as we go on but at least it gives a starting point.

Not wanting the patient to have to get up and down like a yo yo, the examination is divided into as many tests as possible in a particular position. First there is the seated position followed by tests in the supine position, then standing and finally Sim's position for rectal examination. I leave the most uncomfortable examinations to the last.

When I start, the patient is seated. For a moment I just observe. Is there any abnormal tremor as seen in de Musset's sign for an aortic insufficiency or is a Parkinsonian tremor apparent? Are there any observable lesions of the integument? What body type is the patient? Is there a possible Froelich's or Cushing's syndrome? What about lipodystrophy? I press and pinch the integument for turgor and edema. All this takes but a moment. What about body color? Is it pale and bluish as in cyanosis seen in a pulminary involvement, erythematous as seen in hypertension, a jaundice yellow for an hepatic involvement, or a bronze coloration as seen in Addison's disease? Oh what the eyes can tell you with a minute of looking!

The head is then palpated for areas of unusual tenderness. The hair is observed for texture and possible vitamin deficiency. Alopecia areata might also be found which could indicate a more extensive evaluation might be needed to discern a possible venereal disease. Next the cranial nerves are quickly tested from "On Old Olympics Towering Tops ....etc." A cotton pledget with alcohol serves to test the olfactory, a Snellen chart for the optic, eye movements for the oculomotor, trochlear and abducens. The sensory branches of the trigeminal nerves are tested by exciting lid movement through touch and by corneal reflex. The motor branches of the trigeminal are examined by having the patient flex the jaws. The facial nerve is tested by having the patient make faces.

The auditory nerve is observed more thoroughly later, however, I look for possible patient vertigo as a sign of pathology in this nerve. I seldom test the glossopharyngeal unless the patient history has disclosed a problem in the tasting of their food. The Vagus is tested later during my oral examination. I check the Spinal Accessory nerve with neck movements and shoulder shrugging as well as deglutitation. The hypoglossal is then examined observing the tongue for possible unilateral atrophy. All of the preceeding can be done in less than five minutes. Think of all that can be discerned or eliminated from consideration with such a small investment of time!

A glance at the eyebrows tells me of the possibility of tertiary syphilis if there is a marked degree of lateral thinning. Looking at the eyes I observe the medial canthus for possible yellow plaques. This

xanthelasma would indicate a poor lipid metabolism or a possible diabetic condition. Still observing the eyes I look for exophthalmos as seen in hyperthyroidism. The sclera should be free of excessive injection and an arcus senilis around the pupil might tend to confirm a poor lipid metabolism in the elderly. Interstitial keratitis can also be observed at this time. Pupils of unequal size could indicate a history of a CVA or a neurogenic veneral disease condition. Pupillary responses from an Argyll Robertson test are discerned. The fundus is then observed for such conditions as arteriosclerosis, closure of the central artery, diabetes, papilledema, glaucoma, hypertension or nephritis I finish examining the eyes by testing the range of vision.

Moving laterally I palpate the pinna for gouty tophy. Patency of the external auditory meatus is then observed followed by an otoscopic examination of the tympanic membrane. There are times when the drum is not observable due to ceruminosis. It is only at such a time that I will interrupt my examination to remove some of the cerumin. An erythema and tenderness behind the pinna would indicate auricular lymphadenitis, while a tenderness without discoloration would indicate mastoiditis. Auditory acuity is then tested with Weber's and Rinne's tests.

Just looking at the nose without a speculum can tell us a great deal. Dialated nares could indicate a pulmonary problem. A red tipped nose might suggest a positive chronic alcoholism, among other conditions, and blue a cyanotic condition. Flaking of the integuement around the nostrils could be indicative of avitaminosis A. With the speculum I look for septal deviation and the color of the turbinates. A perforated septum could indicate anything from tertiary syphilis to leprosy, disseminated lupus erythematosis, tuberculosis or a poisoning from chrome or arsenic. Transillumination of the sinuses follows.

Moving down to the mouth I observe the color of the lips. If they are pale, an anemic condition could be prevailing while polyposis of the bowels could be indicated in an abnormal freckling. Dry or cracked lips could mean dehydration while excessively moist lips could be indicative of poorly fitting dentures or stomatitis from mercury or iodine. Scarring as seen in rhagades could mean, among other things, a leutic involvement.

The color of the buccal mucosa is important. A yellowing could indicate a jaundiced condition, hence a possible hepatic involvement. Freckles can be seen in Addison's disease and canker sores would demonstrate a herpes infection. White patches for a possible moniliasis, Koplik's spots seen in the prodromal stages of rubeolla, and a dark mucosa as seen in argyria are just some of the things that can be observed with a cursury visualization. A luetic condition can sometimes be indicated by a highly arched palate. In a black patient that highly arched palate could warrant a laboratory evaluation to eliminate the possibility of sickle-cell anemia. A darkly pigmented gingiva might indicate heavy metal poisoning, while hypertrophy could be seen in gingivitis, leukemia and pregnancy. Scurvy, of course, could be indicated with bleeding gums. Hutchinson's teeth, which are thin and notched, is seen as an indication of congenital syphilis. If there are interdental spaces you should try to eliminate the possibility of hyperparathyroidism, Gaucher's disease, acromegaly or hypopituitarism.

A mottling of the teeth can be exhibited when excessive flourine has been ingested.

An abnormally large tongue could be a sign of primary amyloidosis, angioneurotic edema or pellagra among other conditions. Atrophy of the tongue could mean a CNS involvement, or in mild cases it could indicate nutritional problems. Asymmetrical enlargement of the tongue occurs with infections and tumors. I also check the color of the tongue for signs of anemia, pellagra, uremia, Addison's disease or thrush. The surface of the tongue is then examined for signs of hypochlorhydria, vitamin deficiency, moniliasis, or anemia. Glossitis, along with dysphagia and anemia, could mean a Plummer-Vinson's syndrome. The strawberry tongue, of course, would be indicative of scarlet fever. Before leaving this area I palpate the inner surfaces around the gums and sublingually for abnormal masses, such as a ranula under the tongue. A quick look at the tonsilar pillars and pharynx for congestion is followed by an excitation of a gag reflex to test the vagus nerve.

With the last examination I move from the head to the neck. Think of how many things could have already been discerned or eliminated from further consideration and we have just finished examining the head. Almost everything listed so far can be discovered with but a few glances and moves. The important thing is to be drilled in such a manner that you know what to look for and know how to interpret what you see.

Moving caudad I palpate the neck for possible enlargement of the lymph nodes and for movability of the thyroid cartilage. I also palpate the thyroid gland for an enlargement of the Delphian node as is seen in a carcinoma of that area. Inserting my fingers firmly under the cricoid cartilage I have the patient hold his breath. A bouncing with each beat of the heart would be an Oliver's sign and indicative of an aortic aneurysm or of a tumor. If there is a possibility of a hyperthyroid condition I auscultate over the thyroid for bruits. Cervical ROM tests are given to finish my examination of the neck.

Continuing downward, I inspect the thorax for a pectus excavatum or carinatum. A Harrison's groove would be indicative of the patient having had rickets. I auscultate the lungs for rales or the scratchy sounds of pleuritis. After the lungs I listen to the heart. This is followed by percussion and testing for vocal fremitis. Visually I look for spider nevi which could indicate an hepatic problem. If the umbilicus is blue, as in Cullen's sign, I would consider the possibility of hemorrhage in the peritoneal cavity or of pancreatitis.

If the patient is a female I examine the breasts for possible malignancy. An orange peel pitted skin, retracted or bleeding nipples, or unusual dimpling would all indicate a transillumination of the breasts for darkened areas was needed. All are signs of a possible carcinoma.

The blood pressure is then taken on both arms followed by the recording of the pulse and respiration rates. While this is being done the temperature is taken. I next look at the hands for signs of possible pathology as seen in Reynaud's disease, different nodular manifestations observed in various arthritic conditions, or a clubbing of the distal phalanges which could indicate a pulmonary stenosis. Neurovascular compression tests are given in the form of Adson's maneuver, hyperabduction and costoclavicular movements. Right and left hand

strength is tested with the dynamometer, followed by the testing of the deep reflexes, completing the seated examination.

The patient now assumes a supine position. If the patient is a female, the breasts should be palpated. The entire abdominal area is then palpated for tenderness, muscular splinting and abnormal masses or visceral enlargement. Next I have the patient perform an alternate straight leg raise with a Braggard reinforcement, followed by Kernig's test and then Patrick's Faber test to locate possible low back or hip problems. A Soto-Hall test is then performed. Any positive results would require reinforcement tests. A vaginal examination is then given to a female patient with digital palpation and observation. I observe Bartholin's glands for a macule of Sanger and Skene's glands for expression of exudate. If noted, an attempt should be made to milk the urethra. The labia are observed, as are the vaginal walls and the face of the cervix. This is followed by the performance of a Pap test. Before the patient gets up I stroke the plantar surface of the feet for a possible Babinski sign.

With the patient standing I have them perform Kemp's, Romberg's and a Trendelenberg test. All reinforce earlier tests. The patient then bends forward in Adam's position so that I may observe whether any apparent scoliosis is functional or structural. For the male patient I test for an inguinal hernia. This is followed by palpation and transillumination of the testes for possible herniation into the scrotal sac and for tumors. Measurements of the biceps, forearms, thighs, and calves are taken.

For the last time the patient gets on the table and into Sim's position for a rectal examination. The male patient naturally has the prostate examined at this time. I use the disposable anoscope for visualization. I find this better for observation due to the transparency of the scope therefore negating the need for several reinsertions.

This finishes the examination. While it may seem like a lot to some I'm actually only "touching base" in many areas. The important thing is that it gives at least a fleeting cognizance to a variety of areas while concentrating on structures that are important. Some may think I've neglected some important areas and emphasized those that should have been forgotten. The examination was tailored by me to fit the concepts I felt should be satisfied. We all have our favorite way of approaching a challenge and every new patient is just that -- a challenge. What is of prime importance is that the examination is constructed in such a way as to be done quickly, in only 30 minutes or less, and with only a slight alteration of positions on the part of the patient. Hence no one is tired and the information gained is easily catalogued. Too little time, need never be a factor in giving a proper examination.

The one great thing I feel that separates the physician from the therapist is the physician's ability to diagnose the patient's illness and be responsible for the inauguration of the proper theraputic approach. Anyone can give you a pill or stick you with a needle -- only the physician can determine if it should be done and how, and only this can be decided after a proper diagnostic evaluation.

The patient that enters your office is a vibrant living creature. An unspoken message should be transmitted by you to that creature

which is one of empathy, desire to know more and confidence. Unfortunately, the days when a physician diagnosed by smelling the breath, tasting the urine and touching this patient are gone. This has been replaced by sophisticated diagnostic tools, that, while valuable, tend to isolate the doctor from his natural diagnostic skills. The chiropractic physician with his holistic approach should rebel from this often arbitrary concept. Touch the patient. Poke, sniff -- shake if necessary -- but above all -- examine!

HOW TO LIVE WITH MIGRAINE HEADACHES

Part 3

by G. J. Petersen, Ph. D.

This series neither promotes, nor invalidates any school of therapy, but rather seeks to bring to the practicing chiropractic physician the latest information from all disciplines, thus enabling him to more thoroughly understand and evaluate the patient presenting himself for treatment, and to understand and be able to discuss other modes of treatment the patient may be, or may have been receiving. Ed.

Migraine, or bilious sick headache, is a common plague of wide-awake, attractive and well-educated persons. It is so closely correlated with a keen, eager personality that it has been called the disease of the alert mind. It may be some slight comfort to the sufferers to know that their trouble is like a Phi Beta Kappa key, awarded only to the best students at college!

Rarely is a migraine found in a dirt farmer, and then we learn that the patient is unusually intelligent and perhaps a college or university graduate. In one patient we found migraine in a farmer's wife and learned that on weekends she went into town and there ran her club, her church and Community Chest drive.

Similarly, when one day we found migraine in a man who had listed his occupation as "mechanic" it was soon learned that really he was an executive; he was in charge of a machine shop with 100 men under him.

Three out of four women with migraine are short, with such a nice trim figure, such a bright, eager, and intelligent face, and such quick movements and reactions that the nature of their trouble is suspected the minute they walk into the office. In 9 out of 10 cases a few questions show that the woman is a perfectionist who plans her work far ahead, and then sees to it that it is done quickly and just so.

In the office it helps the doctor greatly to recognize these women at a glance because so often they fail to speak of their sick headaches, and in such case, after their examination shows nothing wrong, physicians might be at a loss to explain their troubles. All doctors might be able to say is that their spells of nausea, their tendency to

fatigue, and their general poor health must be "functional", or of nervous origin.

Some persons may ask, "But why didn't the woman mention her headaches?" Perhaps because she had always been so impressed with the severity of the storm in her stomach that she had not noticed that it was usually preceeded by a mild one in the head, or if she had, she did not realize the great diagnostic importance of this fact. She was so sure the storm in her stomach was the primary and all-important one that she expected the doctor to spend all his energies examining her abdomen. It never occurred to her that the storm started in her head and that the cause would have to be looked for there.

In some cases the woman failed to mention headaches because, with the passage of years they had become mild or had largely disappeared, to leave only spells of nausea or abdominal pain. In yet other cases the woman said nothing about headaches because long ago, after many futile treatments and an operation or two, she had given up hope of finding any cure for them.

But still, some student-doctors may ask, "Why in these cases do you consider it so important to get the full story and to make the diagnosis of migraine?" Because, to find that a woman is migrainous tells so much, not only about the nature of the troubles for which she is now seeking relief, but about her whole temperament, and the sort of illnesses she is going to have throughout her life. Also, if we as physicians are really going to straighten her out, we must get her to understand, as she never did before, her inborn nature and the degree to which emotions and life problems affect her health. Only then is she likely to stop looking for some magic medicine or operation, and to settle down to mend her nervous ways and to live within her means of strength, and her husband or family will to learn to help her. With a better understanding of her frailness and hypersensitiveness, and knowing the causes of her attacks, they will be kinder and more considerate and more careful in protecting her from fatigue.

Varying degrees of severity of the attacks. Migraine can be either a mild trouble, not worth talking about, or it can be a terrible affliction which several times a week prostrates the victim. There have been some persons who in their lifetime have had only one blind spell or headache, but that one was so typically migrainous that there could be no doubt about its nature.

Many men and a few women have only short "blind spells," without any headache, while others have a slight headache, or only some nausea or abdominal discomfort. Many who suffered headaches in their youth now are free of them, and have only mild troubles such as short dizzy spells, or brief spells of depression and mental detachment, when they feel only half alive and uninterested in the world about them. A few persons without much if any preliminary headache will occasionally go into a severe spell of abdominal pain and vomiting so alarming that an unwary doctor will think he is dealing with acute appendicitis or intestinal obstruction, and medical doctors have been known to operate. Such attacks, which are called migrainous equivalents, sometimes follow an emotional storm.

Migraine in Men. Why, so far, have we been discussing mainly women? Don't men have migraine? Yes, surely; but they usually have so much easier a time with their headaches that they seldom bother

to consult a doctor. Most of them take two aspirin tablets and keep at work. In but few men does the storm go on to the vomiting stage. Most of the men have much the same temperament as migrainous women have, but, as yet, physicians haven't recognized any characteristic build.

The Diagnosis. One can safely diagnose migraine when one learns that a migrainous type of person is suffering from severe throbbing unilateral headaches which are preceded by a "blind spot" and followed by nausea and vomiting. One can be even more sure if one finds that the headaches are brought on in a typically migrainous way by fatigue, or travel, or some happening out of the usual, and one can be still more sure if one learns that as a child the person came home from school vomiting. One often finds, also, that one or more of the patient's relatives suffered from migraine. Typical is the statement that "aspirin does not help at all".

Interestingly, the word migraine comes from the Latin Hemicrania, which means half of the head. Our grandparents called it the megrims. Unfortunately for the diagnostician, many of the headaches suffered by definitely migrainous people are not unilateral but are felt all over the head. Many are in the back of the neck, high up near the scalp. In such a puzzling case it may help to learn how the headache started. Then one may find that it began in or over one eye, and later, when it got very bad, it spread all over the head. Some persons then feel pain even in the ear lobes and the teeth, and their whole scalp becomes so tender that "every hair hurts".

Just before a headache starts, for about 20 minutes, many migrainous persons suffer from fuzzy vision or a "blind spot" which interferes with reading. In typical cases, with the failure in central vision, there comes a bright pulsating zigzag line which as it lengthens, bows out to one side or the other. Either just before or during a sick headache many persons see bright spots or flashes of light. Others, on closing their eyes, will see faintly luminous clouds.

During a headache a migrainous person may feel chilly and frightened and lonely, as if detached from the world. That the brain is not then working well is shown by the fact that even during the preliminary "blind spell" the person may speak or write words other than the ones which were thought to be spoken or written. Following a headache, the person may have but little memory of what happened.

Often doctors can diagnose migraine the minute they walk into a room and see the woman sitting there in a spell: prostrated, apathetic, fishy-eyed, and entirely different from the charming, wide-awake person they have seen the day before. In milder spells the victim may be able to keep going, but he or she may then be unsocial, taciturn, and mentally-detached from relatives and friends. A young husband, seeing for the first time his bride in a spell, will be puzzled and disturbed at her lack of any sign of interest in him.

Some women, when they are to wake with a headache, get some warning the night before. The husband may note then that his wife is more than usually energetic, talkative, affectionate, or hungry.

The digestive tract is usually normal. Every migrainous person should learn early in life that his or her digestive tract is all right; it is not the seat of the disease. The headachey storm does not start

in the abdomen; to the best of present-day knowledge it starts up in the brain and spreads down the two long vagus nerves into the stomach, just as a similar storm does in the case of seasickness.

When, during vomiting, a little bile comes up, this does not mean, as most people think, that there is something wrong with the liver. Disease in the liver, if present, not only would not cause the migraine, but it would probably for some months keep the headaches from coming! No, bile in the vomitus means only that waves are running backward over the upper part of the small bowel, and causing it to empty into the stomach. Interestingly, even when stones form in the gallbladder they do not cause the headaches. At most, they serve only as a trigger for the migrainous attacks, or they make them more severe when they come.

Headache is only one of the troubles of the migrainous person. Many a migrainous patient is much more concerned with their poor health than with their headaches. They may have learned how to avoid them, or to block them when they come, or they may have learned to put up with them. As a patient once said, rather impatiently, "Stop talking about my headaches. What I want to be cured of are my tenseness, my nervousness, my easy fatiguability, my general sickliness and my inability to keep up with my spouse. I want to be able to go comfortably to a baseball game, or to a night club, or to some vacation-land, without quickly getting tired out and wanting to go home. Perhaps more than anything I want to be so cured that when I make an engagement I can be sure of keeping it".

The mechanisms underlying a migrainous attack. As has been stated, an attack of migraine starts with a storm in the nervous system, a storm which causes a big artery in the brain to so dilate that the blood can go pounding through. Because the blood vessels are among the most sensitive tissues within the skull, their distension causes pain. As one would expect, any drug such as alcohol, which opens up arteries, will tend to bring a headache, while any drug such as ergotamine, which closes down the bore of the arteries, is likely to stop the pain.

Glands of internal secretion. Temporary changes in the glands of internal secretion can either lessen or increase the tendency to migraine. Thus, in women, the sick headaches can come at puberty and go with the menopause, or they can come with menstruation and disappear during pregnancy. If the physician could only identify the substance, perhaps in the blood, which stops migraine during pregnancies, we would have a wonderful cure.

Causes of the Headaches. The most important cause of migraine is the inherited tendency. This is so essential that unless one is born with it and the associated peculiar type of nervous system, one probably cannot have migraine.

Next in importance is some added irritating factor which will sensitize the brain; and finally, there must be something that will trip a sort of trigger in the nervous system. Physicians can think of this trigger as resembling that of the old-fashioned mouse-trap. We have learned that if the trigger was to be set very coarse, it was too hard to trip, and then the mice would get the cheese without getting caught. If the trigger is set too fine, it went off by itself as one walked away.

Sensitizing causes. If a migrainous patient has an easy and happy life, or has just been on a restful vacation, the trigger in one's brain may be set so coarse that it can hardly go off, and then one will go months without a headache. But if the patient is full of worries, annoyances, conflicts, resentments and uncertainties; if they are lying awake night after night contemplating some serious action (off work or divorce); or if they are worn out from nursing a sick spouse or child; their brain will get so irritable, and the trigger will get set so fine, that there can be a headache every day.

One of the most common sensitizing causes of migraine is working under great nervous tension. The hardest thing many patients have to learn is to work quietly and steadily without looking ahead to see the job as done, and without fretting because of this or that. There's the thought of the migrainous bank teller who always "blew up" and got a headache when seeing more than six people standing in front of the wicket. As stated, why worry about them? The job was to wait only on the one person right in front.

It is suspected that a women is migrainous if she admits that when she is to give a dinner she sets the table that morning or the night before! Many patients of this type wear themselves out trying to keep the house too clean, or tying to make the children into perfect little angels. Most sufferers from migraine could be well overnight if they could only learn to be relaxed and easy-going. Certainly physicians never saw migraine in anyone who was.

A great difficulty with many migrainous patients is that with their fine intelligence, their tendency to think clearly as an able person, their faculties of leadership, and their willingness to assume responsibility, the members of the family all come to dump their troubles and worries on them. Often, as is the case, they pick up and carry too big a load of work and leadership in clubs, charitable organizations or professional organizations.

The Great Influence of Psychic Strain. The best story known to show a patient quickly why he or she has severe migraine long after it should have disappeared is that of the nice old prelate who once consulted our office. During the years from 16 to 36, when as an orphan boy he worked very hard, first to put himself through college and then to merit a fine church, he had much trouble with severe migraine. Then, after settling down into a comfortable and happy pastorate, he had no more headaches until, at 60, he was made a bishop and moved to the capitol of his state. There, with a heavy burden of correspondence, much responsibility for raising money, and much need for pouring oil on troubled waters, he got his old migraines back in force. As he said, he knew the cause of his trouble, and he knew how easily he could be cured, but he saw no way of getting back to his old happy mode of life.

Effects of marital satisfactions and dissatisfactions. Because marital dissatisfaction is such a common sensitizing cause of migraine, a research was done on 178 migrainous patients as to what sort of a spouse they had. Some 84 percent said the spouse was wonderfully kind and good and considerate. Many remarked how fortunate this was because they so needed a kind person to nurse them a bit when they were ill.

Unfortunately, 30 of the 178 patients had had to go to the altar twice in order to get the sort of mate they needed. Many of the 30, on marrying early, had chosen an attractive scamp who made love well and danced terrifically but who soon showed that they couldn't be bothered with a sickly spouse. Should one of the spouses get a headache, the other became annoyed and bored, and before long was going out with another companion. On the second try, 7 out of 10 persons involved, with more knowledge of what they needed, got a fine mate.

Some however, when the doctor saw them, were unhappy, and having headaches because the new and usually older mate wasn't much of a lover; often all one could say for them was that they were kind, and a good companion, and a respected member of the community. An average person would probably have looked on the mate as a good catch and would have been satisfied, but the migrainous patient with their great idealism and strong desire to have everything perfect, was not happy; they wanted to be living life beautifully, richly, eventfully and romantically, and they were doing anything but that.

The spouses usually expressed themselves as being well satisfied with their marriage; as they said, when their mate was well the days were so merry and entertaining that they amply made up for the bad days when the spouse was dull.

Predisposing causes of severe migraine, and particularly migraine late in life. When a patient, and particularly an older patient, is having several severe headaches every week or month, several hunches might be noted. One is that in some way they are abusing their brain. They may be full of internal conflicts, resentments, dissatisfactions, unhappinesses, doubts, or unsettled questions, They may be overworking, or carrying too big a burden of responsibility, or struggling with some life problem which they haven't been able to solve, or they may not be getting enough rest or they may be worrying foolishly over something. Occasionally one finds that they are carrying a great sorrow,such as that which comes with a wayward or a defective child. More commonly they are having much trouble with the mother-in-law who is competing with the mate for the love and attention of the other spouse.

In an occasional case they are suffering from a mild unrecognized psychosis which fills them with stormy thoughts and leads them into many conflicts. Another sensitizer in rare cases is an epileptic inheritance. In the cases of older people, who long ago largely lost their migraine, it sometimes comes back after a little stroke.

Things That Trip The Trigger. In a recent article in a medical journal there was listed a few dozen ways in which the migrainous trigger can be tripped so as to bring a spell. One of the commonest of the stimuli is waiting too long for breakfast and, particularly, coffee. Another common stimulus is acute fatigue. An individual will lose sleep; they may have a poor night's rest on a train, or they may get tense on an auto trip, with all its glaring light, or they may lose their temper, or spank a child, or have a fright; or they may see a dog run over in the street, or they may eat some chocolate, or in the female patient start to menstruate and bang - there will go a headache!

The migrainous person is usually so sensitive that a bright light, loud talking at a party, or a strong smell is likely to upset them. They cannot stand for long anything that is shimmering or flickering, and

they cannot look long at certain patterns on floors or walls or fabrics. Migraine might be suspected the minute a patient is noted at blinking at the light coming in through the window of an office.

Anything out of the ordinary routine is likely to upset a migrainous person. An anticipation, and even anticipation of something pleasurable, may bring an upset. One patient remarked, "As a child I never got to a picnic because on that day I always was sick from anticipation". Another stated, "I never packed my bag to go on a trip; my parents had to do it for me because I was too busy vomiting from excitement." As one would expect from all this, the migrainous patients are usually poor travellers and poor sightseers. They cannot shop very long, and have to avoid crowds and functions.

A curious trigger is a sudden letting up of strain. Thus, a businessman may get a migrainous headache when he leaves his office at one o'clock on Saturday; a minister may get a headache on Monday morning, and a nurse may get one on her day off.

Some pnysicians think that migraine is just allergy, but some doctors do not agree. An allergic sensitiveness to some food is just one of the things that can spring the trap. Sometimes it can't even do this. Thus, although one may be migrainous and highly allergic to a number of foods, the eating of one of them never throws some persons into a migrainous attack; it just upsets their stomach.

TO BE CONTINUED: NEXT - THE TREATMENT OF MIGRAINE

References: Walter Alvarez, M. D., Mayo Foundation; Bayard Horton, M..D.
Harry H. Cooke, M. D., Ph. D., F. A. C. S.

ERRATUM: Chirogram Vol. 42, No. 2, February 1975, Page 18
GLUCOSE TOLERANCE TEST: Liver Function Test
Should read: Hyper or Hypoglycemia Test.

NEWS

NEW HOPE AND HELP FOR DIABETICS

A metallic disc no bigger than a quarter may one day help free diabetics from unpleasant insulin injections. The disc is actually a fuel cell that produces a small electric current when in contact with fluids containing sugar.

In diabetes the body fails to properly utilize the sugar it takes in. This is because there is a lack of insulin, a substance secreted by the pancreas and necessary for the metabolism of sugar. Without insulin (or adequate utilization of insulin) there will be too much sugar in the bloodstream throughout the body. When the new disc is planted under the skin or in the abdominal cavity of a diabetic person, it emits an electrical signal which varies in intensity with the amount of glucose in the body tissue fluids surrounding it. According to researchers at the Space Sciences Division of the Whittaker Corporation, the company that developed the disc, this glucose sensor could ultimately be used to actuate a compact insulin dispensing system, also implanted in the body. Thus blood sugar levels would be controlled continuously and automatically. The automatic device would not only relieve the diabetic of his daily insulin injections; it would also be of great value to children with diabetes and mothers whose glucose levels are hard to control. Because of the huge number of diabetics in the United States - approximately one percent of the population the glucose balancing device could probably be mass produced, making its retail cost low enough for everyone to afford.

The implantable sensor has removed a major stumbling block in the development of an "artificial pancreas" according to Dr. J Stuart Soeldner, Assistant Director of the Elliott P. Joslin Research Laboratory. Because the sensor is truly a fuel cell and its electrodes do not dissolve away, there are no galvanic cell effects and no problem with corrosive activity or release of toxic materials. Unlike a battery, the glucose sensor could continue to operate indefinitely inside the body

without recharging. In addition, it is inert and totally compatible with body environment.

The metallic disc is a sensitive regulatory device which responds to the body's own signals. And it signals an important breakthrough in the treatment of diabetes – a breakthrough that should greatly help the one percent of the population who recognize their condition, the more than half million who have diabetes and don't realize it yet, as well as the children of the one out of four Americans who are diabetic.

PHOBIAS

(Preces) Almost everyone is walking around with at least one, often more, unfounded fears tucked into their psyches. Many people readily admit their fears are irrational, yet they continue to go through life avoiding confrontation with them.

Psychiatrists have a name for such obsessive, illogical or unreasoning fears. It's phobias.

Every doctor is familiar with the patient with a bulging medicine cabinet, who pops capsules and pills into his mouth like candy and shrinks from every sneeze or wayward draft as from the plague, which he probably thinks he's about to get. He suffers from hypochondria, the fear of disease. It's a common phobia.

Sometimes people have fears no one has put a psychiatric name to. Take the person who wants to see something of the world, yet is afraid of leaving familiar surroundings and way of life and trying to cope with new situations.

One solution, if one can afford it - would be foreign travel. Holiday Inns suggest staying at an American hotel. That way one can be sure of American comfort and plumbing, of topnotch security, of safe, and wholesome American food - or, authentic local food prepared by native chefs instilled with an American regard for freshness and cleanliness. In short, American carefree comfort is combined with the foreign experience for maximum enjoyment.

A partial list of phobias follows:

Claustrophobia: Fear of closed places, or of stifling. Locking a small child in a closet as a punishment has been known to give rise to this fear.

Agorophobia: Fear of open spaces, or the crossing of a wide street or field unaccompanied. A subtype is kenophobia, the fear of entering a vacant house.

Acrophobia: Fear of high places. This is very common. In its milder forms it can be protective since it keeps people from dangerous situations, such as climbing a crumbly cliff or rickety ladder. But in its more pathological forms it can involve intense fear of places no higher than a low balcony.

Hydrophobia: Fear of water. This has been known to follow neardrownings at an early age, or excessive warning by parents against the dangers of drowning.

Microphobia: Fear of germs.

Mysophobia: Fear of dirt. Microphobia and mysophobia are closely related.

Carcinophobia: Fear of cancer.

Pyrophobia: Fear of fire.

Ailurophobia: Fear of cats. This was a well known Napoleonic phobia, and supposedly afflicted other dictatorial types such as Alexander the Great and Julius Caesar.

The next time a patient gets into a swivit of anxiety over some harmless situation, the physician might consider the possibility of a full-blown phobia, or it may be something that he can nip in the bud with some stiff reasoning. It would be worth the try.

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Contributions to the Library Fund of L. A. C. C. in lieu of flowers in memory of a friend or relative ARE appreciated by the bereaved.

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DR. STACHE PASSES

We regret to announce the passing of Dr. Barbara Anne Stache, the wife of Dr. Meyer Grove, of Los Angeles.

Dr. Stache was a graduate of the Los Angeles College of Chiropractic Class of 1927. She was a member of the Omega Chi Sigma Sorority.

She held a Fellowship in the American Academy of Medical Administrators (F.A.A.M.A.) and was listed as a Hospital Consultant.

Dr. Stache, during her lifetime, made a great contribution to the profession in California through her training and education of Chiropractic Doctors in hospital procedure.

We extend our condolences to Dr. Grove in the loss of his wife, and to the profession in the loss of a fine doctor from its ranks.

In Memoriam

Dr. Clifford Eacrett
Los Angeles, California

†

Dr. John J. Haney
Huntington Beach, California

†

Dr. Jean Fortune Harvey
California

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Dr. Manning B. Strahl
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Dr. Barbara Stache
(Mrs. Meyer Grove)
Los Angeles, California

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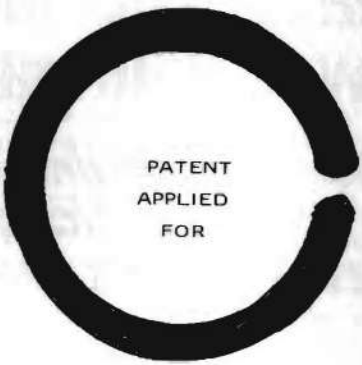

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by
Philip C. Runsten, D. C.
Certified Roentgenologist

1. This appearance of multiple myeloma is not characteristic.

A Multiloculated or "soap bubble" detruction.
B Well defined punched out areas of destruction.
C Diffuse osteoporosis.
D Diffuse medullary destruction in one or more bones.
E Osteosclerosis.

2 Second to the prostate as a source of metastatic carcinoma in the male is the:
A Kidney
B Stomach
C Bladder
D Pancreas
E Lung.

3 About 70% of giant cell tumors occur in the region of:
A The elbow
B The wrist
C The hip
D The knee
E The ankle

4 In supracondylar fractures of the humerus in children the distal fragmant is usually displaced:
A Laterally
B Medially
C Anteriorly
D Posteriorly
E Anterolaterally

5 The combination of oblique fracture of the proximal ulna and dislocation of the radial head is called:
A Barton's
B Smith
C Bennett's
D Colle's
E Monteggia

(ANSWERS ON PAGE 28)

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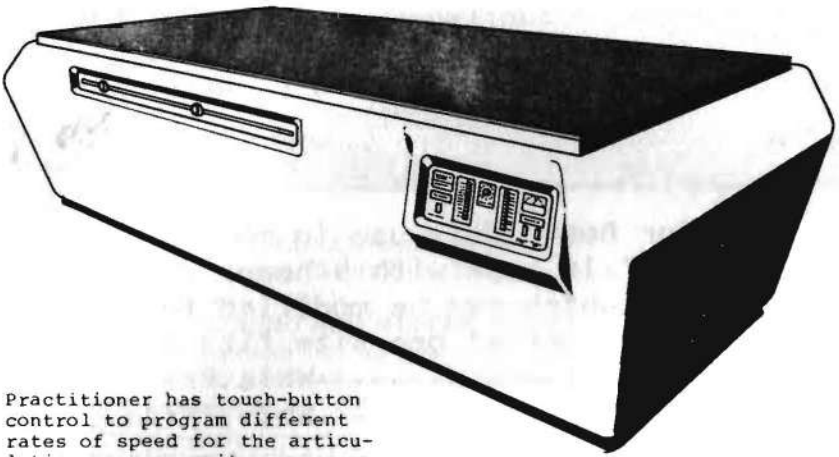

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